Toolkit for Program Success: Linking Community and Health Care Organizations

Leigh Ann Eagle – Executive Director
MAC, Inc. Living Well Center of Excellence

Each Partnership with a Health Care System is Unique

"Forming a partnership with a hospital takes time and persistence; I attended every meeting I could get invited to; it took months before I was heard. Timing is everything!" ***Leigh Ann Eagle, Executive Director, MAC, Inc. Living Well Center of Excellence***

"Population Health Management is a 'team sport' and PRMC cannot resolve the issues of the health care system in isolation. The need to develop community and other clinical relationships and ways of providing care outside of the walls of hospitals has become more important than ever. Hospitals are essentially being held responsible for reducing cost across the healthcare system in Maryland, so it is essential to play a significant role in helping orchestrate access to care and approaches that resolve many of the social problems that prevent people from using health care earlier." ***Karen Poisker, Vice President, Peninsula Regional Medical Center (PRMC)***

Initial Partnership Tools and Resources

- Participant Registry Shared Across Partner Agencies
- Provider Referral Forms
- Reporting Tool for Community/Clinician Referral Forms
- Client Information and Tracking
- Plan of Care Process Flow/Feedback Loop
- Blood Pressure Action Plan and Protocol
- Webinar on Community Services
- CDSM Courses / Access Regionally
- Contribution in Staff and Supervision to Support Effort
- CHW Assessment

Building the Partnership

- Training of hospital staff as Master Trainers/Leaders and implementation of workshops at the hospital and workshops and leader trainings at MAC;
- Hospital team participation in Living Well Eastern Shore Advisory Committee
- Multiple Letters of Support/Commitment by both partners for grant opportunities
- With state requirements for population health focus, expansion of programs (CDSME, Stepping On, PEARLS)
- Collaboration on Community Health Worker pilot and development of webinar and resources highlighting MAC's home and community-based programs
- Department of Health and Mental Hygiene "Million Hearts" funding to support implementation of the Living Well with Hypertension Module; develop processes for referral across Community Health Workers, CDSME and other services

A Multi-Faceted Approach to Meet Client and Health Care Partner Needs

- **Evidence-Based Programs**: CDSME (CDSMP, CPSMP, CTS, DSMP, Stanford CDSMP Home Toolkit), EnhanceFitness, Tai Chi for Better Balance, Stepping On, Hypertension Recruitment Module, PEARLS
- **Referral and Plan of Care Process Loop**: evidence-based programs, provider, homecare-based CHW for monitoring of clinical outcomes, AAA-based CHW for home and community-based services
- **Hospital services provided at MAC:** staff support for evidence-based program implementation, cancer (support and navigation, organic garden, teaching kitchen), weight loss center (monitored exercise, nutritional counseling, teaching kitchen)

Key Strategies for Scaling and Sustainability

- Building sustainable partnerships with health care systems for program support and reimbursement
- Linking clinical outcomes to evidence-based healthy aging programs
- Quality assurance and tracking measures to communicate participant engagement in behavior change and self-management to providers
- Bundling an array of healthy aging programs to improve participants' health outcomes and quality of life

Assessing Patient Risk and Referral to Evidence-Based Programs

Chronic Disease Assessment

- Do you have 2 or more chronic medical conditions?
- Are you taking more than 5 medications?
- Do you have difficulty managing your condition(s)?

Falls Risk Assessment for patients over 65

- Have you fallen in the past year?
- Do you feel unsteady when standing or walking?
- Do you worry about falling?

Depression Screen: Over the past two weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things
- Feeling down, depressed or hopeless

Linking Clinical and Quality of Life Outcomes to Evidence-Based Programs

- Utilize a hypertension recruitment module and blood pressure screening to identify risk and engage/refer participants
- Provider referrals identify chronic disease and identify appropriate program intervention
- Care Transitions Team utilizes online HIPAA compliant Autofill referral
- Embedding standardized chronic disease, falls, depression risk assessments into hospital, provider and AAA referrals (soon to include malnutrition screening)

Quality Assurance, Referral and Tracking Measures

- Hospital's Accountable Care Organization measures include requirement to refer to CDSME
  - Pulling patient panels by disease for workshop referrals
  - Satisfaction survey self-efficacy questions align with ACO quality measures
- With participants' permission, we link participants back to health care provider to determine changes in utilization at the local level

Bundling Healthy Aging Programs to Improve Health Outcomes and Quality of Life

- Budget line item support for CDSME, Stepping On, PEARLS workshop delivery; support for staff for implementation, data collection and reporting, administration
- Cancer Thriving and Surviving provided within a wide array of Cancer Survivor services (community garden, tasting kitchen, weekly organic vegetable, EnhanceFitness boot camp, support groups co-located at MAC in partnership with hospital
- PRMC Weight Loss Center co-located at MAC (community garden and kitchen, gym privileges)
  - PRMC clinical staff
  - Referral to DSMT or HBAI based on diagnosis
  - DPP and/or Enhance Fitness as ongoing benefit for individuals

Contact Information

Leigh Ann Eagle
MAC, Inc. Living Well Center of Excellence
LAE2@macinc.org
410-742-0505 x 136